Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN029S	A. BUILDING _____ B. WING _____	08/26/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD REHABILITATION CENTER	2045 SILVERADA BLVD. RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments Surveyor: 11911 This Statement of Deficiencies was generated as the result of a complaint investigation conducted in your facility on August 26, 2005 under the State Licensure Regulations for Skilled Nursing Facilities concerning the care and services given to the resident. Complaint #NV00009271 alleged that a resident was transported to an emergency room on 8/22/05, and reported to be dehydrated, dirty, and neglected by the transferring facility. The resident died at the acute care hospital on 8/25/05. The complaint was substantiated and deficiencies were cited under the Nevada Administrative Code for Skilled Nursing Facilities. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Z 000		
Z230	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Surveyor: 11911 Based on medical record review, staff interview,	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z230	Continued From page 1 and observation it was determined that the facility failed to provide services and treatment that were necessary to attain or maintain the patient's highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment for one resident. Findings include: Resident #1: The resident was admitted to the facility on 6/5/05 with diagnoses which included osteoarthritis, status post cerebral vascular disease with hemiplegia, obesity, urinary incontinence with a Foley catheter, decubitus ulcers, edema and failure to thrive. The resident was responsive to questions. Resident #1 was observed on 8/1/05 lying on an air bed. The air bed was used to reduce pressure on pressure areas. The resident's hands were in a clenched fist position and her lips were dry and flaky. The urine in the Foley catheter drainage bag was a dark brown colored. Later that day, the resident was asked to show the surveyor her tongue. Her tongue was dry and appeared to have deep crevices in the middle part of the tongue. Resident #1 had the same dry, flaky appearance to her lips throughout the survey. Due to the contractures of both hands the resident was not able to perform any of her own care. During the first day of the survey, Resident #1 was noted to have a strong odor that emanated from her person. During an observation of wound treatments the surveyor placed a finger into the fist like contractures of the resident's hands. When the surveyors finger was removed the surveyor noted a very strong odor on her finger. The staff smelled the odor and it	Z230		

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Z230	Continued From page 2 was determined that the resident had not had her contracted hands cleaned for quite some time. The left hand was gently opened as far as possible and the staff were shown the resident's fingernails on the contracted hand. The nails of the 2nd, 3rd, and 4th digits were dark brown in color. It was evident from the odor and the appearance of the resident's fingernails that resident's hands had not been cleaned or her nails cared for. On the second day of the survey, 8/2/05, the resident was observed sitting in a wheelchair. She had protective booties (Moon boots) on both feet due to leg contractures and that she was unable to reposition her legs or feet. Her right heel had a decubitus ulcer that had a dry pink area with a blackened circular area that circled the pink middle of the wound. Her left heel had an unopened pressure area. Both of her feet were noted to be very dry and flaky. The skin on the top of her feet had a white appearance due to the dryness of the skin. This observation was also make on the 3rd and 4th days of the survey. No staff was observed to apply any type of moisturizer to the resident's feet during the survey. On 8/2/05, at approximately 12:15 PM, Resident #1 was observed sitting up in her wheelchair. One of the surveyors went past the room and spoke to the resident and then placed the resident's call light on. A second surveyor came into the room and Surveyor #1 stated that the resident had said that she wanted to go back to bed. The second surveyor stayed with the resident. Resident #1 stated that her bottom hurt and she needed to be put back to bed and get off of her buttocks. The surveyor examined the wheelchair and found out that the resident did not	Z230		

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Z230	Continued From page 3 have her Gel Cushion, a pressure reducing pad, in the chair as ordered. The resident with two Stage II open areas on her buttocks and one large bleeding Stage IV wound on the coccyx area had been placed in her wheelchair without the benefit of any padding. The surveyor went into the hallway and told the medication nurse that the resident wanted to go back to bed. Fifteen minutes later the resident was placed back on her special pressure reducing air bed by way of a Hoyer lift and the assistance of three staff members. She stated relief to be back in a lying position. On 8/21/05, at approximately 10:00 PM, Resident #1 was sent to the acute care emergency room (ER) for evaluation due to her refusal to eat or drink, loose watery stools, and being non-responsive. The resident was admitted to the hospital with the diagnoses which included severe dehydration, severe decubitus ulcer, urosepsis, and altered mental status. The ER physician wrote that "she arrived in the emergency room in totally unacceptable condition. She is extremely dirty and unbathed. She has a stage IV decubitus ulcer on her sacrum. She has purulent urine and purulent vaginal discharge." On the history and physical under the heading of impressions the physician wrote "In my opinion, evidence of severe, unacceptable neglect from the nursing facility that transferred her. This lady arrives in the medical condition that clearly did not happen over the last several hours. She is obviously severely dehydrated. She is quite dirty and has not been bathed in days." The resident expired on 8/25/05. Severity 4 Scope 1	Z230		

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Z266	Continued From page 4	Z266		
Z266	NAC 449.74477 Pressure Sores Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shell ensure that a patient: 2. With pressure sore receives the services and treatment needed to promote healing, prevent infection and prevent new sores from developing. This Regulation is not met as evidenced by: Surveyor: 11911 Based on direct observation, interview, and record review it was determined that the facility failed to provide care, services and treatment to promote healing and to prevent new open areas, to a resident that had entered the facility with open pressure areas. Findings include: Resident #1: The resident was admitted to the facility on 6/5/05 with diagnoses which included osteoarthritis, status post cerebral vascular disease with hemiplegia, obesity, urinary incontinence with a Foley catheter, decubitus ulcers, edema and failure to thrive. The resident was admitted to the facility with multiple skin problems that included: 1. Three Stage II pressure ulcers on her coccyx. One measured 3 cm by 1 cm and two measured 2 cm by 1 cm. All had sero sanguinous drainage. 2. A Stage II on the left posterior thigh which measured 4 cm x 2 cm. 3. A Stage III ulcer on the right inner thigh that measured 2 cm by 2 cm by 1.3 cm with 80% yellow slough and sero purulent drainage. During the course of the resident's stay, Resident #1 acquired new decubitus ulcers that the facility failed to document and describe. The following is	Z266		

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Z266	Continued From page 5 a synopsis of the facility's documentation of the progression of the resident's wounds following the initial assessment after admission to the facility: 6/11/05--No new skin problems noticed. 6/14/05-- Two of the resident's coccyx wounds had healed. The one that remained had improved and measured 1 cm by 1.5 cm by 0.3 cm. 6/18/05--The weekly skin sheet indicated three Stage II wounds on the coccyx area, a Stage III wound on the left inner thigh and a Stage II on the posterior thigh. No measurements were indicated for the two new coccyx wounds or any description as to color, size or exact location. 6/23/05--One of the wounds on the coccyx area was "much worse" and was bleeding. The measurements indicated that the left and right thigh pressure ulcers had increased in size. 6/28/05--Three coccyx wounds were documented on the weekly skin work sheet. One wound on the coccyx was noted to have gone from a Stage III to a Stage II. Two others were documented as Stage II. The size, color or depth coccyx wounds was not documented. 6/30/05--The coccyx, left and right thigh were noted to be improving. The entry did not mention the other two coccyx wounds noted on 6/28/05. 7/1/05-- One coccyx wound, one left posterior thigh wound, and one right inner thigh wound were documented. The right inner thigh wound had increased from a Stage II to a Stage III. No measurements were documented.	Z266		

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Z266	Continued From page 6 7/11/05--Two new wounds mentioned in the documentation. One was an unopened blister on the right heel (Stage I) and the second was a Stage II to the right buttocks. No measurements or descriptions as to color, size, depth, etc. were noted. Physician orders for treatments were obtained. 7/15/05--A new open area was noted on the resident's back. No measurements or description were documented. 7/12/05--The entry on the "weekly skin check work sheet" read, "Treatment on-going to multiple pressure ulcers. Oral fluids encouraged." There was no further explanation concerning the wounds except for a circle around the buttocks of the body map (drawing of a human body, one front view and one back view) and two straight lines one to the right posterior (back) thigh and one to the left anterior (front) thigh. 7/15/05--Another new open area was noted on the resident's back. There were physician orders for this open blistered area but again no wound documentation or description, such as exact location size, color, depth, etc. 7/21/05--The wounds on the back and the coccyx area had gotten worse. The coccyx area was a Stage IV and the back open blister measured 5 cm by 2 cm. 7/28/05--A new open area on the right calf was was documented but did not include measurements or a description. For the first time there was documentation of a black area on the left heel that was a Stage III. There was also mention of two more wounds on the coccyx with	Z266		

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Z266	Continued From page 7	Z266		

measurements of 1 cm by 5 cm and 1.5 cm by 1 cm. Whether or not these were the same open areas that were documented on 6/28/05 and not mentioned again in any of the wound documentation was not discernable.

An observation of wound care for multiple wounds was conducted on 8/1/05 at approximately 2:00 PM. The resident was lying on an air bed which was used to reduce pressure on bony prominences. Dressing changes were done on the left great toe, right heel, the right inner thigh, the right posterior thigh, the coccyx area, and the lower back. The following observations of the resident's wounds and skin condition were made:

1. Resident #1 had a blackened right heel with a pink colored center and granulating tissue. This area was a Stage III and was found in the wound documentation only once on 7/28/05. There was a unopened pressure area on her left heel. Moon boots to both of her heels were ordered due to the pressure areas. On the first day of the survey the left boot was not on nor was it located in the resident's room. Staff had to go to the laundry to get the boot.

2. The resident's right and left thighs had creases which were reddened and with dried scab-like skin. In the creases some of the scabs had flaked off leaving open skin underneath.

3. The coccyx area had three open areas. There was a very large open bleeding area over the coccyx bone and two smaller areas on the right and left buttock areas. The wound nurse was asked to stage the wounds. She indicated that the large area was a Stage IV and the two smaller areas were Stage II. There was

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Z266	Continued From page 8 documentation by the wound nurse that the area over the coccyx bone measured 10 cm by 6 cm. This area was not measured the day of the treatment observation. Peri care was required and observed prior to the coccyx dressing changes. The resident's peri area was extremely reddened. No treatment or topical ointment was placed on reddened area. The reddened peri area and the creases in the resident's thighs were not documented on any of the wound sheets. Treatments to the coccyx area were ordered daily which would have allowed staff to assess the thighs and peri area of Resident #1 and observe the potential risk for further skin breakdown. 4. There was a large area in the middle of the resident's back that was open and had serosanguinous drainage. The area was elongated and went straight across the resident's lower back and had been assessed as Stage III. 5. A dressing to the right hand was noted. Staff stated that the resident had sustained a skin tear. No documentation was available concerning the treatment to the skin tear to the right hand. On 8/2/05, at approximately 12:15 PM, Resident #1 was observed sitting up in her wheelchair. One of the surveyors went past the room and spoke to the resident and then placed the resident's call light on. A second surveyor came into the room and Surveyor #1 stated that the resident had said that she wanted to go back to bed. The second surveyor stayed with the resident. Resident #1 stated that her bottom hurt and she needed to be put back to bed and get off of her buttocks. The surveyor examined the wheelchair and found out that the resident did not have her Gel Cushion, a pressure reducing pad, in the chair as ordered. The resident with two	Z266		

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Z266	Continued From page 9 Stage II open areas on her buttocks and one large bleeding Stage IV wound on the coccyx area had been placed in her wheelchair without the benefit of any padding. The surveyor went into the hallway and told the medication nurse that the resident wanted to go back to bed. Fifteen minutes later the resident was placed back on her special pressure reducing air bed by way of a Hoyer lift and the assistance of three staff members. She stated relief to be back in a lying position. On 8/21/05, at approximately 10:00 PM, Resident #1 was sent to the acute care emergency room (ER), for evaluation due to her refusal to eat or drink, loose watery stools and being non-responsive. The Resident was admitted to the hospital from the ER with diagnoses which included severe dehydration, severe decubitus ulcer, urosepsis, and altered mental status. The physician wrote that "she arrived in the emergency room in totally unacceptable condition. She is extremely dirty and unbathed. She has a stage IV decubitus ulcer on her sacrum. She has purulent urine and purulent vaginal discharge." She is obviously severely dehydrated. She is quite dirty and has not been bathed in days." Resident #1 expired, at the acute care hospital, on 8/25/05. Severity 4 Scope 1	Z266		
Z290	NAC 449.74487 Nutritional Health; Hydration 1. Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that: (a) The nutritional health of the patient is maintained, including, without limitation, the maintenance of his weight and levels of protein,	Z290		

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Z290	Continued From page 10 unless the nutritional health of the patient cannot be maintained because of his medical condition. (b) The patient receives a therapeutic diet if such a diet is required by the patient. This Regulation is not met as evidenced by: Surveyor: 11911 Based on record review and staff interview it was determined that the facility failed to ensure for one patient, that the nutritional health of a patient was maintained including the maintenance of her weight. Findings include: Resident #1: The resident was admitted to the facility on 6/5/05 with diagnoses which included osteoarthritis, status post cerebral vascular disease with hemiplegia, obesity, urinary incontinence with a Foley catheter, decubitus ulcers, edema and failure to thrive. The dietician did an initial assessment on 6/8/05 that recognized Resident #1's need for nutritional interventions to promote wound healing. A pureed diet with increased protein and large portions, 2300 calories and 105 grams of protein, was recommended to promote wound healing. The resident's admission weight was 234. 4 pounds. She was 63 inches tall. The resident's ideal body weight (IBW) was documented at 115 pounds with an adjusted IBW of 139 pounds. Her usual weight was 230 pounds. A second nutritional assessment was done on 7/20/05 and increased the calories to 2400 and protein to 114 grams daily. It was expected that the resident would lose some weight as she had edema and was taking diuretics. The resident's weights were recorded as follows: 6/7/05 234.4 lbs.	Z290		

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Z290	Continued From page 11 6/22/05 230.2 lbs, 6/30/05 224.4 lbs, 7/11/05 221.0 lbs and 7/25/05 202.4 lbs. This was a total weight loss of 32 lbs in 49 days with an 18.6 (8.4%) pound loss in 14 days (7/11/05 - 7/25/05) for Resident #1. On 8/3/05, the staff were asked the facility's procedure when a resident had such a weight discrepancy in two weeks. They stated that dietary should have been notified. A discussion with the dietician revealed that she had been notified concerning the weight loss, but had not assessed the weight loss to date. This was eight days later. The surveyor was told that the dietician was at the facility 10 hours a week. Resident #1 was unable to feed herself due to contractures of both hands. She was totally dependent on staff to be fed. A review of the meal percentages listed on the ADL sheets revealed that the resident's consumption of meals had fluctuated up and down since admission. Review of meal percentages consumed from 7/11/05 through 7/25/05 revealed that the highest percentage eaten by the resident was 65% on one evening meal and the next highest was 50% for a total of five meals. The percentages of meals consumed the days of 7/22/05 through 7/25/05 was not documented. Out of approximately 45 meals, Resident #1 ate 50% or better for six meals. The diet order was written for increased protein and large portions to aid in wound healing. (Refer to Tag Z266- Pressure sores.) The documented evidence did not reflect that Resident #1 was taking in enough of the extra calories and protein, on a consistent basis, to ensure their benefit. The resident was never placed on a nutritional supplement until surveyors	Z290		

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Z290	Continued From page 12 asked about the use of a dietary supplement. On 8/21/2005, at approximately 10:00 PM, Resident #1 was sent to the acute care emergency room, for evaluation due to her refusal to eat or drink, loose watery stools and being non-responsive. The resident was admitted to the hospital from the ER with diagnoses which included severe dehydration, severe decubitus ulcer, urosepsis, and altered mental status. The resident expired, at the acute care hospital, on 8/25/05. Severity 4 Scope 1	Z290		
Z291	NAC449.74487 Nutritional Health; Hydration 2. A facility for skilled nursing shall provide each patient in the facility with sufficient fluids to maintain proper hydration and health. . This Regulation is not met as evidenced by: Surveyor: 11911 Based on medical record review, direct observation and staff interview it was determined that the facility failed to ensure for one patient, that sufficient fluids were provided to maintain proper hydration and health. Findings include: Resident #1: The resident was admitted to the facility on 6/5/05 with diagnoses which included osteoarthritis, status post cerebral vascular disease with hemiplegia, obesity, urinary incontinence with a Foley catheter, multiple open decubitus ulcers, edema and failure to thrive. Resident #1 was observed on 8/1/05, the first day of the survey to be lying in an air bed used to	Z291		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z291	Continued From page 13 reduce pressure on bony prominences. She was also noted to have hands that were contracted into fist like shapes. The resident was totally dependent on staff for all of her ADL needs including acquiring food and drink. The resident's Foley catheter was observed to be draining a dark brown colored urine. The resident was responsive to questions; when she spoke the surveyor noticed that her lips had a dry and flaky appearance. Later that day she was asked to show the surveyor her tongue. The surveyor demonstrated sticking out her tongue and the resident demonstrated the action back. Her tongue had a dry white colored appearance with deep crevices in the middle part of the tongue. Resident #1 had a care plan dated 7/7/05 that noted that the resident was to be encouraged to take up to 2000 cc's of fluids per day. She had a second care plan dated 7/20/05, that noted that 1500 cc's of fluid per day were to be provided with meals. From this documentation, Resident #1 should have been receiving between 1500 and 2000 cc's of fluids per day, to have sufficient fluid intake. Resident #1 had a Foley catheter and on the first day of the survey the urine from this catheter was a brownish color. On the other days of the survey the urine was noted to be a dark amber color with some sediment. Review of the Intake and Output records of the resident revealed that of 49 days (6/7/05 through 7/29/05) there were only 11 days that the resident's fluid intake was 1500 cc's or greater. These numbers did not meet the recommended care plan adequacy for fluid intake. When asked who was to monitor the intake and output records the staff stated that the Director of Nursing collected and totaled the I&O sheets. The Director of Nursing stated that she had been behind in calculating these sheets. It was also noted that on the first	Z291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN029S	A. BUILDING _____ B. WING _____	08/26/2005

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Z291	Continued From page 14 day of the survey there was no water pitcher next to the resident's bed with which the staff could have offered the resident a drink. Review of the same time frame (6/7/05 through 7/29/05) revealed 13 days that the resident's Foley catheter output was more than the resident's fluid intake. On the 8/2/05, during a conversation with the medication pass nurse, the surveyor was told that Resident #1 would drink whenever it was offered to her. It was not until the third day of the survey (8/3/05) that a water pitcher, a cup and a straw were noted by the resident's bed and it was not until that day that the surveyor noted anyone offering the resident a drink other than with her meals. On 8/21/05, at approximately 10:00 PM, Resident #1 was sent to the acute care emergency room (ER) for evaluation due to her refusal to eat or drink, loose watery stools and being non-responsive. Resident #1 was admitted to the hospital from the ER with diagnoses which included severe dehydration, severe decubitus ulcer, urosepsis, and altered mental status. The physician wrote that "she arrived in the emergency room in totally unacceptable condition. She is extremely dirty and unbathed. She has a stage IV decubitus ulcer on her sacrum. She has purulent urine and purulent vaginal discharge." On the history and physical under the heading of impressions the physician wrote "In my opinion, evidence of severe, unacceptable neglect from the nursing facility that transferred her. This lady arrives in the medical condition that clearly did not happen over the last several hours. She is obviously severely dehydrated. She is quite dirty and has not been	Z291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z291	Continued From page 15 bathed in days." Resident #1 expired on 8/25/05. Severity 4 Scope 1	Z291		
Z300	NAC 449.74491 Prohibited practices 1. A facility for skilled nursing shall adopt and carry out written policies and procedures that prohibit: a) The mistreatment and neglect of the patients in the facility; b) The verbal, sexual, physical and mental abuse of the patients in the facility; c) Corporal punishment and involuntary seclusion; and d) The misappropriation of the property of the patients in the facility. This Regulation is not met as evidenced by: Surveyor: 11911 Based on record review, observation and interview it was determined that the facility failed to ensure that procedures to prohibit mistreatment and/or neglect of one patient were carried out. Findings include: Refer to the deficiencies cited at Tags Z230 (Standards of Care), Z266 (Pressure Sores), Z290(Nutritional Health), and Z291 (Hydration). Resident #1: On 8/21/05, at approximately 10:00 PM, the resident was sent to the acute care emergency room (ER), for evaluation due to her refusal to eat or drink, loose watery stools and being non-responsive. The resident was admitted to the hospital from the ER with diagnoses which included severe dehydration, severe decubitus ulcer, urosepsis, and altered	Z300		

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Z300	Continued From page 16 mental status. The physician wrote that "she arrived in the emergency room in totally unacceptable condition. She is extremely dirty and unbathed. She has a stage IV decubitus ulcer on her sacrum. She has purulent urine and purulent vaginal discharge." On the history and physical under the heading of impressions the physician wrote "In my opinion, evidence of severe, unacceptable neglect from the nursing facility that transferred her. This lady arrives in the medical condition that clearly did not happen over the last several hours. She is obviously severely dehydrated. She is quite dirty and has not been bathed in days." Social Service notes dated 8/22/05, indicated that the social worker had met with the doctor concerning the condition that the resident presented into the emergency room. The Social worker's documentation revealed that she had met with the RN, reviewed the record, and then made a report, stating the condition of the resident, to the Ombudsman's Office. Resident #1 died at the acute care facility on 8/25/05. Severity 4 Scope 1	Z300		